

Instructions for preparing and submitting your Supporting Documentation:

Supporting Documentation or a prescription may be required to provide information about a product or service that might not otherwise be eligible.

Prescription for OTC Medicines and Drugs – use this form to submit a prescription for over-the-counter medicines and drugs, such as pain relievers, cold & flu remedies or antihistamines.

Proof of Medical Care – use this form to obtain and/or submit supporting documentation for a medical, dental or vision expense.

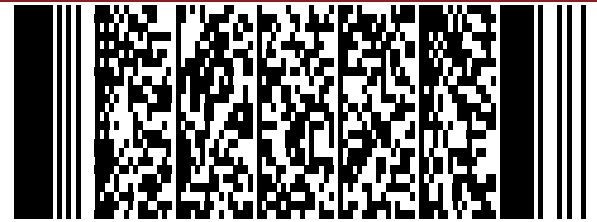
Orthodontia Documentation – use this form to submit your contract for orthodontia expenses.

Information to Remember when submitting Health Care FSA Supporting Documentation

The information provided here is to assist you and/or your health care provider in providing the information we need to process your claim.

Supporting documentation should be submitted with your first reimbursement request for the service or product. Once received, this documentation will remain archived on your account and can be applied to claims within the timeframe specified and submitted after the supporting documentation is processed. Additional documentation will be needed for expense(s) incurred outside of the dates below or if no dates are provided.

Submitting supporting documentation does not guarantee your claim will be reimbursed. Payment of claims will be based on the rules set forth in the applicable regulations, your employer's plan design and on the information in the required substantiation documentation. An itemized purchase receipt or Explanation of Benefits (EOB) from your insurance provider must be provided for each claim expense. Additional information on eligibility requirements and receipt requirements can be located on the ADP Spending Account website.



Limited Purpose Supporting Documentation: Proof of Medical Care Form

This document and any attachments are intended solely for the use of the sender and ADP and may contain information that is privileged and confidential. If you are not the intended recipient or its authorized representative, you are hereby notified that dissemination of this information is strictly prohibited. If you received this information in error, notify the sender immediately and destroy this document and all supporting attachments.

Participant

Use this form when an expense requires proof of medical care in addition to your purchase receipt. You may view comprehensive lists of eligible/ineligible items, including items that may require additional documentation, in the expense lists located on the ADP Spending Account website (www.flexdirect.adp.com) by selecting Spending Accounts → Learn More.

1. Complete the participant section using blue or black ink.
2. Have your authorized provider complete and sign the physician/authorized provider section below.
3. Submit this form with the medical information to ADP for consideration of your expense. You may submit this documentation by itself or with a claim form submitted for the incurred service or product.

Note: In lieu of step two above, you may attach proof of medical care documentation from your doctor, such as a letter of medical necessity, as long as the information is current.

Please Fax Completed Form To
1- (866) 392-4090

Do not include a cover page or the instructions pages with your fax.

Or mail to: ADP Claims Processing, P.O. Box 1853, Alpharetta, GA 30023-1853.

Employee Information

Name _____

City _____

State

Zip

FlexID

Locate your FlexID at www.flexdirect.adp.com or by calling the Solution Center at 1-800-654-6695.

Employer _____

Type of Service (Completely fill in the box for only one)

☐ Dental

☐ Vision

Proof of Medical Care (Completely fill in the box for only one)

☐ Attached

☐ Completed Below

Physician/Authorized Provider

Per general flexible spending account (FSA) eligibility guidelines, health care services and products are only eligible for reimbursement from a Health Care Flexible Spending Account (HCFSA) if the expense(s) was incurred for medical care and not cosmetic purposes or general health. Certain products or services may require supporting documentation that shows the expense was incurred for medical care.

Please provide the information below for consideration of the participant's request for claim reimbursement. Completion of all information is NECESSARY for processing. If this information is not completed, the HCFSA reimbursement will be denied.

Product or service

Patient Name

Length indicated

Please indicate date (MM/DD/YYYY) when the use of product or service for medical care began. This date may be a past date.

From / /

Please indicate date (MM/DD/YYYY) when the use of product or service for medical care will end or select Indefinite if applicable.

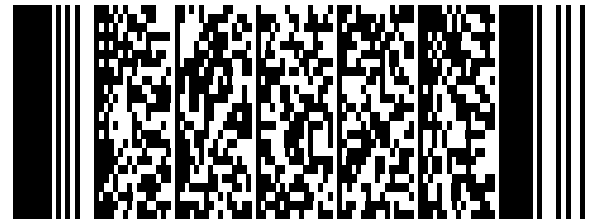
To / /

Or ☐ Indefinite

Provider Name (please print) _____

Provider Signature _____

Date _____



Limited Purpose Supporting Documentation: Orthodontia Documentation

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Employee Information

Name _____

City _____

State

Zip

FlexID

Locate your FlexID at www.flexdirect.adp.com or by calling the Solution Center at 1-800-654-6695.

Employer _____

Participant

There are two options to receive reimbursement for orthodontia claims:

Option 1. Lump sum – submit the orthodontia contract (or other documentation that identifies orthodontia service) and proof of payment along with your signed claim form. You may be reimbursed up to the amount you have paid for orthodontia that does not exceed your annual election amount.

OR

Option 2. Periodically (e.g. monthly, quarterly, etc.) – submit the orthodontia contract (or other documentation that identifies orthodontia service) and proof of payment (e.g. payment receipt provided by your dentist) with your signed claim form. Your orthodontia contract (or other orthodontia documentation) will remain archived on your account and can be applied to future orthodontia claims within the timeframe specified by the contract. However, you will need to submit proof of payment (e.g. monthly, quarterly, etc.) with each claim request.

You may submit your orthodontia contract with your first reimbursement request for the service or product or by filling in the information below and submitting this form with your contract. Note: if your dental provider's coupon payment or payment receipt indicates service for orthodontia, then you may not need to submit the orthodontia contract.

Please Fax Completed Form and Orthodontia Contract To
1- (866) 392-4090

Do not include a cover page or the instructions pages with your fax.

Or mail to: ADP Claims Processing, P.O. Box 1853, Alpharetta, GA 30023-1853.